

FLU VACCINE QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

- | | | |
|---|-----|----|
| 1.) Any previous allergic reactions to the flu shot? | Yes | No |
| 2.) Do you have any allergies to eggs? | Yes | No |
| 3.) Are you currently on coumadin or aspirin? | Yes | No |
| 4.) Do you currently have a fever? | Yes | No |
| 5.) If over the age of 60: Have you had a shingles vaccination? | Yes | No |
| 6.) Last year flu vaccine was received? _____ | | |
| 7.) Last year pneumococcal vaccine was received? _____ | | |

Do you have any of the following conditions?

- | | | |
|---|-----|----|
| Diabetes mellitus or glucose intolerance | Yes | No |
| Heart disease or hypertension | Yes | No |
| COPD or asthma | Yes | No |
| Immunosuppression secondary to cancer, chemotherapy | Yes | No |
| History of spleen removed or sickle cell disease | Yes | No |
| Allergies requiring allergy shots | Yes | No |

Other conditions, please explain:

Patient's/Guardian's Signature: _____

Office Use Only

Flu vaccine 0.5ml given in Right / Left arm Lot# _____ Exp _____

Pneumococcal vaccine 0.5ml given? Yes No

If yes, Right /Left arm Lot# _____ Exp _____

Pharmacist Initials: _____